EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) AND HEALTH CHECK

MEDICAID FOR CHILDREN

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WHY HEALTH CHECK / EPSDT ARE IMPORTANT

- Promotes preventative health care by providing for early and regular medical and dental screenings.

- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.

HEALTH CHECK / EPSDT OVERVIEW

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** defined by federal law and includes:
  - Periodic Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care

EPSDT OVERVIEW
CON'T.

- Rehabilitative services for developmental disabilities
- Mental health and substance abuse services
- Medical and adaptive equipment
- Transportation
- In-home nursing, personal care, and specialized therapies
- Out-of-home residential, facility and hospital services
- Other medically necessary care

EPSDT OVERVIEW

CON'T.

- Recipients under 21 must be afforded access to the full array of EPSDT services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

EPSDT OVERVIEW

CON'T.

Under EPSDT, North Carolina Medicaid has an explicit obligation to make available a variety of individual and group providers qualified and willing to provide EPSDT services.

EPSDT CRITERIA

- Required to cover any service that is medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".

EPSDT CRITERIA

CON'T.

"Ameliorate" means to:

- improve or maintain the recipient's health in the best condition possible,
- compensate for a health problem,
- prevent it from worsening, or
- prevent the development of additional health problems.

EPSDT CRITERIA

CON'T.

EPSDT covers short-term and long-term services as long as the requested services will correct or ameliorate the child's condition. For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not ameliorate the child's condition taken as a whole, but need only be medically necessary to ameliorate one of the child's diagnoses or medical conditions.

EPSDT also covers personal care services, wheelchairs, and other medical services or equipment which are needed to compensate for a health problem or maintain the child's health in the best condition possible.

EPSDT CRITERIA
CON'T.

- Must be determined to be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental, investigational.

EPSDT CRITERIA
CON'T.

- Must be safe.
- Must be effective.

EPSDT CRITERIA
CON'T.

- Must be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to a free choice of providers.

EPSDT CRITERIA
CON'T.

It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

EPSDT FEATURES

- No Waiting List for EPSDT Services
- No Monetary Cap on the Total Cost of EPSDT Services

EPSDT FEATURES
CON'T.

- No Upper Limit on the Number of Hours under EPSDT

- No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician

EPSDT FEATURES
CON'T.

- No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

- No Co-payment or Other Cost to the Recipient

EPSDT FEATURES
CON'T.

- Coverage for Services that Are Never Covered for Recipients Over 21 Years of Age

- Coverage for Services Not Listed in the N.C. State Medicaid Plan

IMPORTANT POINTS ABOUT EPSDT

- The full array of EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

IMPORTANT POINTS ABOUT EPSDT

CON'T.

- Does **NOT** eliminate the need for prior approval if prior approval is required.

IMPORTANT POINTS ABOUT EPSDT

CON'T.

- EPSDT services do not have to be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.

EPSDT OPERATIONAL PRINCIPLES

- The decision to approve or deny the request under EPSDT must be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The prohibition in CAP/C on skilled nursing for purposes of monitoring does not apply to EPSDT services if skilled monitoring is medically necessary.

- Case management is an EPSDT service and must be provided to a child with a Medicaid card if medically necessary to correct or ameliorate regardless of eligibility for a CAP waiver or CAP budgetary limitations.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Durable medical equipment (DME), assistive technology, orthotics, prosthetics, or other service requested do **NOT** have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- EPSDT requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to a free choice of providers.

EPSDT OPERATIONAL PRINCIPLES
CON'T.

- It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, law that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

1. "This is the responsibility of the school system."

2. "Close supervision, redirection, safety monitoring, assistance with mobility and other ADL's, improving socialization and community involvement, and controlling behavior are not service goals covered under EPSDT."

3. "The services would not correct or improve the child's diagnosis."

EPSDT OPERATIONAL PRINCIPLES

CON'T.

4. "EPSDT criteria do not include monitoring a child's actions for event which may occur."

5. "EPSDT services are not long term or ongoing."

6. "Teaching coping skills cannot be covered under EPSDT."

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- CAP appeals will be considered under both the CAP criteria **AND** EPSDT. Specifically, the definition of amelioration is in effect and must be applied to pending appeals.

EPSDT OPERATIONAL PRINCIPLES

CON'T.

- The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

EPSDT COVERAGE AND CAP WAIVERS

- Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit unless the waiver service is **ALSO** an EPSDT service (e.g. durable medical equipment).

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **ANY** child enrolled in a CAP program can receive **BOTH** waiver services and EPSDT services. However, if over budget and Medicaid eligible, the request will be reviewed under EPSDT criteria.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- If enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD), prior approval to exceed $85,000 per year must be obtained.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). **It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP-MRDD recipients.**

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **Only** a CAP/DA case managers can deny, reduce, or terminate a CAP/DA waiver service.

- All EPSDT requests must be forwarded to the DMA CAP/DA consultants for review and response.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **A CAP/C or CAP-MRDD case manager may not deny, either formally or informally, a waiver or EPSDT service request supported by a licensed clinician.**

  CAP/C: Requests must be forwarded to DMA CAP/C Nurse Consultants.

  CAP-MRDD: Requests must be forwarded to ValueOptions for recipients under 21 years of age who receive services under the CAP-MRDD waiver, as well as for children not in a waiver who have a case manager.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

Any request for services **OR** appeal under CAP must also be considered under EPSDT as well as under the CAP provisions if the appeal is for a child with Medicaid.

EPSDT COVERAGE AND MH/DD/SA SERVICES

- Staff employed by local management entities (LMEs) **CANNOT** deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.

EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or the DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.

EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.

EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

EPSDT COVERAGE AND MH/DD/SA SERVICES

CON'T.

- All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE

- Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan. If the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- When requesting prior approval for a covered service, providers should refer to the Basic Medicaid Billing Guide, section 6. Requests should be submitted to the appropriate vendor as specified in that section.

REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

- Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(a) of the Social Security Act for recipients under 21 years of age.

REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- Requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to:

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- Requests for Medicaid prior approval of DME and orthotics and prosthetics under EPSDT that do not appear on DMA's lists of covered equipment, including pediatric home mobility aids and augmentative communication devices, should be submitted to:

REQUESTING PA FOR A NON-COVERED STATE MEDICAID PLAN SERVICES

CON'T.

CSHS/POMCS (Purchase of Medical Care Services)
NC Division of Public Health
1904 Mail Service Center
Raleigh, NC 27699-1904
Telephone #: 919-855-3701
FAX #: 919-715-3848

Specify that the request is for a Medicaid recipient under 21 years of age so that CSHS staff will recognize that EPSDT applies. Medicaid due process procedures will be applied to the request.

DOCUMENTATION REQUIREMENTS

- Documentation for either covered or non-covered state Medicaid plan services (medical, dental, or MH/DD/SA) should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

- This includes a discussion about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure. Should additional information be required, the provider will be contacted.

DOCUMENTATION REQUIREMENTS
CON'T.

- Requests for non-covered state Medicaid plan services may be submitted on the Non-Covered State Medicaid Plan Services Request form.

- This form is located on the DMA website:

www.ncdhhs.gov/dma/forms/noncoveredservicesrequest.pdf

INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS

- Vendors (EDS, ACS Pharmacy, CCME, and ValueOptions) may receive service requests from providers for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests should be forwarded to the appropriate vendor for review. For example:

INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS
CON'T.

- If ValueOptions receives a request for breast surgery, the request should be forwarded to the prior approval section at EDS.

- Should EDS receive a request for physical therapy, the request should be forwarded to CCME.

INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS
CON'T.

- Should a vendor receive a request for Medicaid Personal Care Services (PCS) for a recipient **under 21 years of age**, the request should be forwarded to DMA, PCS Nurse Consultant, if the PCS clinical policy requires prior approval for the service requested in that case.

INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS

CON'T.

It should be noted that there may be a delay in making a decision when a provider sends a prior approval request to a vendor for which the vendor is not responsible for conducting the prior approval review. Once the request is received by the appropriate vendor, a decision will be reached promptly, usually within 15 business days of receipt of the request by the appropriate vendor.

OUTREACH

- A special mailing, addressing EPSDT and how to request EPSDT services, will be distributed to recipients and their legal representatives.

- This policy instruction shall be posted at both DMA and DMH websites.

OUTREACH
CON'T.

- DMA and DMH will regularly inform their staff, related DHHS Divisions, vendors, agents, Medicaid providers, families, and other agencies working with children on Medicaid (e.g. schools, Headstart, WIC, Smart Start, etc.) about this EPSDT policy and its procedures for EPSDT services (including DME equipment/supplies).

OUTREACH
CON'T.

- A summary of this policy and procedure, and a reference to the website address where it is posted, will be included in the Medicaid Consumer Guide for Families, in annual inserts with Medicaid cards, and in Medicaid provider bulletin articles at least annually.

THE END

Questions?